

Complete Summary

GUIDELINE TITLE

Prevention, diagnosis and treatment of failure to progress in obstetrical labor.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Prevention, diagnosis and treatment of failure to progress in obstetrical labor. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Oct. 35 p. [40 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Institute for Clinical Systems Improvement (ICSI). Prevention, diagnosis and treatment of failure to progress in obstetrical labor. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Oct. 35 p.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Failure to progress in obstetrical labor

GUIDELINE CATEGORY

Diagnosis
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To prevent unnecessary protracted labor with use of the Failure to Progress in Obstetrical Labor guideline and its methods (e.g., timely monitoring)
- To increase the use of procedures that assist in progress to vaginal birth
- To increase the percent of women whose birth expectations include the potential use of techniques such as amniotomy, oxytocin or other interventions related to utilizing the Failure to Progress in Obstetrical Labor guideline

TARGET POPULATION

This guideline is intended for a limited population. This guideline does not apply to inductions. All of the following parameters must be present before application of the guideline is deemed appropriate:

- Nullipara female
- No concomitant medical problems
- Pregnancy at or greater than 36 weeks
- Having contractions
- Singleton fetus
- Cephalic presentation
- No evidence of fetal distress
- Caregiver expects normal spontaneous vaginal delivery

Note: If there is any medical question about whether a patient fits these parameters, the guideline should not be applied to that patient.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Antepartum labor and delivery education regarding the active management of labor, including information about medications
2. Intrapartum care including chart evaluation; frequent cervical examinations; amniotomy in absence of spontaneous rupture or contraindications; supportive care/comfort measures; pain relief using parenteral analgesics

- such as nalbuphine hydrochloride (Nubain), butorphanol tartrate (Stadol), meperidine (Demerol), or hydroxyzine hydrochloride (Vistaril) or epidural or intrathecal narcotics; documentation of progress of labor; and monitoring of fetal heart rate
3. Active management of labor for failure to progress including evaluation of potential causes; amniotomy (if not previously performed); analgesia; oxytocin augmentation, with electronic monitoring of fetal heart tones and uterine contractions; and obstetrical/surgical consult if necessary
 4. Management of protraction disorders including evaluation of maternal position, fetus position, and fluid balance; oxytocin augmentation, and obstetric/surgical consult if necessary
 5. Management of uterine hyperstimulation including changing the maternal position, administering oxygen, shutting off pitocin until recovery, and possible administration of terbutaline.
 6. Vaginal delivery
 7. Operative vaginal delivery including vacuum extraction or mid/low forceps delivery for continued failure to progress
 8. Cesarean delivery for failure to progress after 2 to 4 hours of active management of labor or after evaluating other options (including operative vaginal delivery) as appropriate

MAJOR OUTCOMES CONSIDERED

- Duration of labor
- Effectiveness of active management of labor in reducing cesarean deliveries
- Rate and type of delivery including spontaneous vaginal, forceps, vacuum extraction or cesarean delivery
- Adverse fetal, neonatal and perinatal outcomes (morbidity and mortality)
- Adverse maternal outcomes
- Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Key conclusions (as determined by the work group) are supported by a conclusion grading worksheet that summarizes the important studies pertaining to the conclusion. Individual studies are classed according to the system presented below, and are designated as positive, negative, or neutral to reflect the study quality.

Conclusion Grades:

Grade I: The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II: The evidence consists of results from studies of strong design for answering the question addressed, but there is uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

Study Quality Designations

The quality of the primary research reports and systematic reviews are designated in the following ways on the conclusion grading worksheets:

Positive: indicates that the report or review has clearly addressed issues of inclusion/exclusion, bias, generalizability, and data collection and analysis.

Negative: indicates that these issues (inclusion/exclusion, bias, generalizability, and data collection and analysis) have not been adequately addressed.

Neutral: indicates that the report or review is neither exceptionally strong nor exceptionally weak.

Not Applicable: indicates that the report is not a primary reference or a systematic review and therefore the quality has not been assessed.

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline annotation, discussion and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member groups during an eight-week review period.

Each of the Institute's participating member groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating member groups following implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group

Following the completion of the review period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary and a written response is prepared to address each of the responses received from member groups. Two members of the OB/GYN Steering Committee carefully review the input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of four questions: (1) Is there consensus among all ICSI member groups and hospitals on the content of the guideline document? (2) Has the drafting work group answered all criticisms reasonably from the member groups? (3) Within the knowledge of the appointed reviewer, is the evidence cited in the document current and not out-of-

date? (4) Is the document sufficiently similar to the prior edition that a more thorough review (critical review) is not needed by the member group? The committee then either approves the guideline for release as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Member groups may introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer and other practice systems. Evaluation and assessment occurs throughout the pilot test phase, which usually lasts for three-six months. At the end of the pilot test phase, ICSI staff and the leader of the work group conduct an interview with the member groups participating in the pilot test phase to review their experience and gather comments, suggestions, and implementation tools.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline; the OB/GYN Steering Committee reviews the revised guideline and approves it for release.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendations pertaining to prevention, diagnosis, and treatment of failure to progress in obstetrical labor are presented in the form of an algorithm with 18 components, accompanied by detailed annotations. An algorithm is provided for [Prevention, Diagnosis, and Treatment of Failure to Progress in Obstetrical Labor](#). Clinical highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) and conclusion grade (I-III, Not Assignable) definitions are repeated at the end of the "Major Recommendations" field.

Clinical Highlights and Recommendations

1. Confirm active labor before admitting to facility evidenced by:
 - Spontaneous contractions at least 2 per 15 minutes, and two or more:
 - Complete effacement of cervix
 - Cervical dilation greater than or equal to 3 cm
 - Spontaneous rupturing of membranes (SROM)

(see Annotation #3)

2. Perform amniotomy early in labor unless one or more of the following occurs:
 - Spontaneous rupture of membranes
 - Presentation unknown, floating or unstable
 - Cervix dilated less than 3 cm
 - Patient refuses

(see Annotation #7)

3. Conduct frequent cervical checks (cervical checks afford best opportunity to detect labor progress and prevent failure to progress). (see Annotation #8)
4. Augment with oxytocin to achieve adequate labor for 2 to 4 hours. (see Annotation #9)
5. If patient is in Stage II labor and is not making progress, initiate management of protraction disorders (positioning, fluid balance, oxytocin augmentation, obstetrical/surgical consult). (see Annotation #13)
6. Consider operative vaginal delivery or cesarean delivery. (see Annotations #16 and #18)

Prevention, Diagnosis, and Treatment of Failure to Progress in Obstetrical Labor Algorithm Annotations

1. Antepartum 32 Weeks Labor and Delivery Education

Patient and provider should discuss potential need for active management of labor, including information about medications.

2. Phone Triage for Labor

Hospital and/or clinic phone triage for the labor patient will include these questions. Triage staff will assess general questions from obstetrical experience. Some questions may require more details for assessment. Generally the patient is encouraged to remain home as long as possible. The caregiver will manage any/all medical concerns according to accepted standards.

General Questions:

- Are you having contractions?
- Is this your first baby?
- Was your cervix dilated at least 2-3 cm on your last office visit?
- Did you have medical complications during your pregnancy? Get specifics.
- Are you at term? (What is your estimated date of conception?)

Specific Questions:

- Is your baby moving as usual?
If no, advise go to hospital.
- Has your water broken?
If yes, advise go to hospital.
- Are you bleeding?
If yes, advise go to hospital.
- Are you having unbearable contractions?
If yes, advise go to hospital

3. Is Patient in Labor?

Labor is defined as:

Spontaneous contractions at least 2 per 15 minutes and at least two of the following:

- Complete effacement of cervix
- Cervical dilation 3 cm or greater (Cervical exam #1)
- Spontaneous rupturing of membranes (SROM)

Evidence supporting this recommendation is of class: R

Only patients who meet this definition of labor should be admitted for careful management of labor. Careful assessment of presenting patients is critical.

Patients who are not in labor should receive education which includes signs to look for, changes to assess, and reassurance that they can come back to the hospital when changes occur. (See Annotation Appendix A, "Patient Education Handout" in the original guideline document.) A patient may be placed on "hold" status for observation. Hold patients require medical reassessment before leaving the hospital.

5. Intrapartum Care

Characteristics of care for a patient at the time of admission to labor and delivery include:

- Chart evaluation
- Cervical exam # 2
- Appropriate supportive care/comfort measures as per individual provider (may include but are not limited to: by mouth fluids, maintain fluid balance, position changes, back rubs, music, ambulation, and tub bath/shower).

Evidence supporting this recommendation is of classes: C, D

- Adequate pain relief. This includes parenteral analgesics: (e.g., nalbuphine hydrochloride [such as Nubain], butorphanol tartrate [such as Stadol], meperidine [such as Demerol], or hydroxyzine hydrochloride [such as Vistaril] or epidural or intrathecal narcotics for patients in active progressing labor [continued dilation of the cervix]).
- Documentation of progress of labor using a graphic medium (partogram) is started on admission.

Evidence supporting this recommendation is of classes: A, C, M, R

- Monitor fetal heart rate (see the National Guideline Clearinghouse [NGC] summary of the Institute for Clinical Systems Improvement [ICSI] guideline [Intrapartum Fetal Heart Rate Management](#)).

7. Amniotomy Unless Contraindicated

Amniotomy should be done early in labor unless spontaneous rupture has occurred or contraindications are present. Early amniotomy reduces the need for failure to progress protocol. It is part of the prevention of failure to progress. Contraindications include:

- Presentation unknown, floating or unstable
- Cervix dilated less than 3 cm
- Patient refuses

Evidence supporting this recommendation is of classes: A, M

8. Less than 1 cm Dilation for 2 Consecutive Hours?

Labor progress is measured in dilation of the cervix. The only way to make this assessment is to do cervical checks. Cervical checks should indicate at least 1 cm dilation per hour. Frequent cervical checks afford the best opportunity for prevention of failure to progress.

Evidence supporting this recommendation is of classes: A, C, R

9. Failure to Progress Diagnosis/Management of Labor

Failure to progress is defined as cervical changes of less than 1 cm per hour for 2 consecutive hours. Active management of labor does not reduce the rate of cesarean delivery but may decrease the length of labor and increase patient satisfaction in nulliparas. [Conclusion grade II: See Conclusion Grading Worksheet - Appendix A - Annotation #9 "Active Management of Labor" in the original guideline document]

The sequence of management of labor includes:

1. Evaluation of potential causes (check adequacy of labor with internal monitor). Adequate contractions are counted as a minimum of 200 montevideo units per 10-minute blocks of time over a 2-hour time period.
2. Artificial rupture of membranes if membranes are intact and there are no contraindications (see Annotation #7, above).
3. Ensure adequate analgesia as deemed appropriate by care provider.
4. Oxytocin augmentation according to hospital protocol.
Contraindications include unknown presentation or floating/unstable; patient refuses; unable to monitor contractions adequately.

Electronic monitoring of fetal heart tones and uterine contractions is necessary when oxytocin is administered. Refer to the NGC summary of the ICSI guideline [Intrapartum Fetal Heart Rate Management](#) (see Annotation #7) for criteria to guide discontinuance of oxytocin augmentation.

Because of the risk of uterine hyperstimulation, an intrauterine pressure catheter should be encouraged in conjunction with a high-dose oxytocin protocol.

Uterine hyperstimulation is defined as contractions lasting longer than 90 seconds, or more than five contractions in 10 minutes. Contractions can be managed by changing the maternal position and administering oxygen, shutting off the pitocin until recovery has occurred and possibly the administration of terbutaline 0.25 mg subcutaneously.

5. Obtain an obstetrical/surgical consult if necessary. Cesarean delivery is done when patient is not making progress for 2 to 4 hours (regardless of oxytocin dosage or duration of oxytocin) after adequate contraction pattern has been achieved on maximum oxytocin dose appropriately used.

Evidence supporting this recommendation is of classes: A, C, D, M, R

10. Stage II Labor

When patient has reached Stage II labor a reassessment at least every 30 minutes x2 is done to assess descent of the fetus and rotation of the fetus. If the patient is making appropriate progress, the caregiver can anticipate vaginal delivery. Fetal descent should be greater than 1 cm per hour.

Evidence supporting this recommendation is of class: R

13. Management of Protraction Disorders

If the patient in Stage II labor is not making progress, management of protraction disorders will include:

- Evaluation of maternal position and fetus position. Consider having the patient move into different positions
- Evaluation of fluid balance
- Oxytocin augmentation for failed Stage II unless contraindicated (see Annotation #10, above)
- Obstetrical/surgical consult if necessary

Evidence supporting this recommendation is of classes: B, R

16. Operative Vaginal Delivery Contraindicated?

When the above measures fail, the caregiver will consider operative vaginal delivery including vacuum extraction or mid/low forceps delivery unless contraindicated. Vacuum extraction contraindications include:

- Presenting part is too high
- Provider is inexperienced
- Fetal distress with inability to do timely operative vaginal delivery
- Patient refuses

Note: When using vacuum extraction or forceps application with a suspected macrosomic infant, be aware of the risk of shoulder dystocia.

Evidence supporting this recommendation is of classes: C, D, R

Cesarean Delivery

After evaluating these options, caregiver will perform a cesarean delivery when necessary. Education for vaginal birth after cesarean trial of labor is given before discharge. See the NGC summary of the ICSI guideline [Vaginal Birth After Cesarean](#).

Evidence supporting this recommendation is of class: C

Definitions:

Conclusion Grades:

Grade I : The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II : The evidence consists of results from studies of strong design for answering the question addressed, but there is uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III : The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for [Prevention, Diagnosis, and Treatment of Failure to Progress in Obstetrical Labor](#).

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline contains an annotated bibliography and discussion of the evidence supporting each recommendation. The type of supporting evidence is classified for selected recommendations (see "Major Recommendations.")

In addition, key conclusions contained in the Work Group's algorithm are supported by a grading worksheet that summarizes the important studies pertaining to the conclusion. The type and quality of the evidence supporting

these key recommendations (i.e., the use of active management of labor) is graded for each study.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate medical management of failure to progress in obstetrical labor
- Reduced morbidity and mortality associated with failure to progress in obstetrical labor
- Increased clinician and patient satisfaction with outcomes

POTENTIAL HARMS

- Because of the risk of uterine hyperstimulation, an intrauterine pressure catheter should be encouraged in conjunction with a high dose oxytocin protocol.
- Vacuum extraction or forceps application with a suspected macrosomic infant carries the risk of shoulder dystocia.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Amniotomy contraindications include: presentation unknown, floating or unstable; cervix dilated less than 3 cm; patient refuses
- Contraindications to oxytocin augmentation include: unknown presentation or floating/unstable, patient refuses, unable to monitor contractions adequately
- Vacuum extraction contraindications include: presenting part is too high, provider is inexperienced, fetal distress with inability to do timely operative vaginal delivery, patient refuses

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions.
- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- Note that if there is any medical question about whether a patient fits the parameters outlined in "Target Population," the guideline should not be applied to that patient.
- The recommendations in this guideline are supported by large controlled studies. The guideline work group would prefer to refer to double-blind

studies, but it is not feasible to blind a woman to whether she is having labor or a delivery. It is unsafe to blind care providers to whether a woman has had previous labor and delivery failure and/or complications. Given these limitations, the work group feels confident of the literature support for the recommendations within this guideline.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for release, a member group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

IMPLEMENTATION TOOLS

Clinical Algorithm
Quality Measures

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED NQMC MEASURES

- [Prevention, diagnosis and treatment of failure to progress in obstetrical labor: percent of women in the guideline population who have spontaneous rupture of membranes \(SROM\) or early amniotomy.](#)
- [Prevention, diagnosis and treatment of failure to progress in obstetrical labor: percent of women in the guideline population with failure to progress diagnosis who have oxytocin.](#)
- [Prevention, diagnosis and treatment of failure to progress in obstetrical labor: percent of women in the guideline population with education on active management for failure to progress.](#)

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Prevention, diagnosis and treatment of failure to progress in obstetrical labor. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Oct. 35 p. [40 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1994 Sep (revised 2004 Oct)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals

and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

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SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

OB/GYN Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: John Jefferies, MD (Work Group Leader) (Mayo Clinic) (Obstetrics/Gynecology); Leslie Atwood, MD (Allina Medical Clinic) (Family Practice); Lori Bates, MD (Mayo Clinic) (Family Practice); Brendon Cullinan, MD (Montevideo Clinic) (Family Practice); Mark Matthias, MD (Hutchinson Medical Center) (Family Practice); Dale Akkerman, MD (Park Nicollet Health Services) (Obstetrics/Gynecology); Amy Knox, CNM (Park Nicollet Health Services) (Nurse Midwife); Cherida McCall, CNM (HealthPartners Medical Group) (Nurse Midwife); Michele Stegeman, CNM (HealthPartners Medical Group) (Nurse Midwife); Brielle Stoyke, CNM (CentraCare) (Nurse Midwife); Ruth Wingeier, CNM (CentraCare) (Nurse Midwife); Jenny Senti, APRN (Altru Health System) (Nursing); Rick Carlson, MS (HealthPartners) (Measurement Advisor); Nancy Jaeckels (Institute for Clinical Systems Improvement) (Implementation Advisor); Nancy Greer, PhD (Institute for Clinical Systems Improvement) (Evidence Analyst); Linda Setterlund, MT, MA (Institute for Clinical Systems Improvement) (Facilitator)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, ICSI has adopted a policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse impact on the content of the guideline. Readers of the guideline may assume that only work group members listed below have potential conflict of interest to disclose.

No work group members have potential conflicts of interest to disclose.

ICSI's conflict of interest policy and procedures are available for review on ICSI's website at www.icsi.org.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Institute for Clinical Systems Improvement (ICSI). Prevention, diagnosis and treatment of failure to progress in obstetrical labor. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Oct. 35 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [Institute for Clinical Systems Improvement \(ICSI\) Web site](#).

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- ICSI pocket guidelines. April 2004 edition. Bloomington (MN): Institute for Clinical Systems Improvement, 2004. 404 p.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1999. The information was verified by the guideline developer on August 4, 1999. This summary was updated by ECRI on October 13, 2000 and January 15, 2002. This summary was updated on March 13, 2003. The updated information was verified by the guideline developer on May 15, 2003. This summary was updated on July 15, 2004 and January 4, 2005.

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